Revision Changes October 2002

This table contains a listing of updates to the *Alabama Medicaid Provider Manual.* The table lists the affected section of the manual, a description of the update, the updated pages to insert, and affected pages to remove. This update replaces the entire manual.

To update your paper copy of the manual, replace the pages listed in the column called “Remove old pages” with the change pages you receive in the mail accompanying this update log.

To request additional copies of the *Alabama Medicaid Provider Manual* update, contact the EDS Provider Assistance Center by calling 1-800-688-7989.

You can also go to http://www.medicaid.state.al.us to download a complete, updated, electronic version of the *Alabama Medicaid Provider Manual* from Medicaid’s web site.

This online version already contains the updates in this log. Find out more about the online version of the *Alabama Medicaid Provider Manual* in Chapter 1, Section 1.2, Using the Online Version of the Manual.

Affected Chapter	***Description of Change***	***Remove old pages***	***Insert updated pages***
Table of Contents	**Replaced pages of Table of Contents to reflect October 2002 Revision**	i to xxvi	i to xxviii
Chapter 1 Introduction	**No changes**	1-1 to 1-12	1-1 to 1-12
Chapter 2 Becoming a Medicaid Member	**No changes**	2-1 to 2-4	2-1 to 2-4
Chapter 3 Verifying Recipient Eligibility	**No changes**	3-1 to 3-20	3-1 to 3-20
Chapter 4 Obtaining Prior Authorization	**No changes**	4-1 to 4-10	4-1 to 4-10
Chapter 5 Filing Claims	**Section 5.9.1 Online Adjustments:** Providers can submit electronic adjustments using the EDS Provider Electronic Software or vendor-supplied software designed using specifications received from EDS. Through this process, providers can ~~adjust~~ recoup previously paid claims with dates of service up to three years old. Claims within the timely filing limit may be adjusted for correction and resubmitted for accurate payment the same day the electronic adjustment is made. Once the system returns an acknowledgement that the ~~adjustment~~ recoupment has been accepted, the provider then resubmits the claim for processing as a new claim.	5-1 to 5-34	5-1 to 5-34
Chapter 6 Receiving Reimbursement	**No changes**	6-1 to 6-8	6-1 to 6-8
Chapter 7 Understanding Your Rights and Responsibilities as a Providers	**No changes**	7-1 to 7-8	7-1 to 7-8

Affected Chapter	*Description of Change*	*Remove old pages*	*Insert updated pages*
Chapter 8 Ambulance (Ground & Air)	**Section 8.3 Prior Authorization and Referral Requirements - Authorization for Air Transportation:** Added to first bullet - Copy of the EPSDT referral form (no longer required for dates of service after 6/1/02) **Section 8.5.3 Procedure Codes and Modifiers - Procedure Codes for Basic Life Support (BLS) Services Table:** A0380 - BLS mileage, per mile (30 miles or more requires prior authorization) Deleted 6/1/2002 A0425 - Ground Mileage, per mile (30 miles or more requires prior authorization) Effective 4/1/2002 **Procedure Codes for Advanced Life Support (ALS) Services:** A0427 - Ambulance service, advanced life support, ~~non-~~emergency transport, Level 1 (ALS1) A0390 - ALS mileage, per mile (30 miles or more requires prior authorization) Deleted 6/1/2002 **Procedure Codes for Non-emergency Services:** A0380 - BLS mileage, per mile (30 miles or more requires prior authorization) Deleted 6/1/2002 A0390 - ALS mileage, per mile (30 miles or more requires prior authorization) Deleted 6/1/2002 A0425 - Ground Mileage, per mile (30 miles or more requires prior authorization) Effective 4/1/2002 Q3019 - Ambulance service, ALS vehicle used, emergency transport. No ALS level service furnished. Effective 4/1/2002 Q3020 - Ambulance service, ALS vehicle used, non-emergency transport. No ALS level service furnished. Effective 4/1/2002 **Services Not Covered by Medicare That Are Covered by Medicaid** • A0324-A0326, A0360, A0380-A0390, A0422, A0425, A0426, A0428, Q3020 • Second Modifiers 1A, 5A, 6A, 7A, 1B, 2B, 3B, 4B, 7B, 8B, 9B, 1C, or 2C	8-1 to 8-12	8-1 to 8-12
Chapter 9 Ambulatory Surgical Centers (ASC)	**No changes**	9-1 to 9-6	9-1 to 9-6
Chapter 10 Audiology/Hearing Services	**No changes**	10-1 to 10-6	10-1 to 10-6
Chapter 11 Chiropractor	**No changes**	11-1 to 11-4	11-1 to 11-4
Chapter 12 Comprehensive Outpatient Rehabilitation Facility (CORF)	**No changes**	12-1 to 12-4	12-1 to 12-4

Affected Chapter	*Description of Change*	*Remove old pages*	*Insert updated pages*
Chapter 13 Dentist	**Section 13.2 Informed Consent** Informed consent shall be documented in the record for all patients for whom comprehensive treatment is to be provided. This informed consent shall include all diagnoses, an explanation of any treatment, therapies, reasonable alternative therapies, their risks, and prognosis. All informed consents shall be signed by the patient or parent (guardian). If a blanket informed consent is used, a note that such a form was reviewed should be made in the progress notes. Consistent violation of the informed consent requirement can result in further investigation and appropriate action. **Section 13.3.1 Examinations - Limited Oral Examination (Problem Focused):** This procedure cannot be billed in conjunction with periodic or comprehensive oral examinations. Limited to one per provider/provider group per year. **Section 13.3.5Stainless Steel Crown** The following are indications for placement of stainless steel crowns (prefabricated crown forms) for fitting on individual teeth: • For the restoration of primary and permanent teeth with caries, cervical decalcification, and/or development defects (hypoplasia and hypocalcification) • When the failure of other restorative materials is likely with interproximal caries extended beyond line angles • Following pulpotomy or pulpectomy • For restoring a primary tooth being used as an abutment for a space maintainer, or • For restoring fractured teeth when the tooth cannot be restored with other restorative materials. **Section 13.6.3 Procedure Codes and Modifiers - Diagnostic Clinical Oral Examinations:** D0140 - Limited oral evaluation – problem focused (emergency treatment) Limited to one per provider/provider group per year - No **Section 13.6.3 Procedure Codes and Modifiers - Radiographs - Other Restorative Services Table:** D2940 - Sedative fillings (not to be used ~~with~~ as liners or bases~~)~~ under restorations) - No	13-1 to 13-18	13-1 to 13-18
Chapter 14 Durable Medical Equipment (DME)	**Section 14.2.2 Durable Medical Equipment - Suction Pump, Home Model, Portable (E0600):** EDS must receive a request for coverage within ~~**seven working**~~ **thirty calendar days** after the date the pump is dispensed. **Home Blood Glucose Monitor (E0607):** The dispensing provider must submit documentation that justifies at least two of the medical criteria above to EDS for prior authorization within ~~**seven working**~~ **thirty calendar days** from the date the equipment was dispensed. **External Ambulatory Infusion Pump (E0784) -** Added entire section	14-1 to 14-58	14-1 to 14-60

Affected Chapter	*Description of Change*	*Remove old pages*	*Insert updated pages*
	Glucose Test or Reagent Strips and Lancets (A4253, A4259): If additional strips or lancets are needed and at least two of the above medical criteria continue to be met, a prior authorization request must be submitted by the dispensing provider to EDS within ~~**seven state working**~~ **thirty calendar days** from the date the item was dispensed. **External Infusion Pump, and Supplies (E0784, A4232, A4221):** **E0784** - External Ambulatory Infusion Pump will be limited to one every five years based on submitted documentation. This procedure code will be a capped rental item with rental payment of $360.00 per month for twelve months. At the end of the twelve month period the item is considered to be a purchased item for the recipient paid in full by Medicaid. Any maintenance/repair cost would be subject to an EPSDT screening and referral and a prior authorization as addressed under current Medicaid policy. **A4232** - Syringe with needle for External Insulin Pump, sterile 3cc (each) will be supplied in quantities prescribed as medically necessary by the physician. **A4221** - Supplies for maintenance of drug infusion catheter per week will be limited to three supply kits per week; no more than twelve supply kits per month. These supply kits must be prescribed as medically necessary by the recipient's physician. If additional supply kits are needed an EPSDT screening and referral and a prior authorization must be submitted to Medicaid for review and approval. **Hospital Bed/Mattress/Bed Side Rails (E0250, E0255) (K0456)** A physician must prescribe bedside rails as medically necessary in order for a recipient to qualify for Medicaid reimbursement. EDS must receive the request for coverage within ~~**seven working**~~ **thirty calendar days** after the date that the equipment was dispensed. The recipient must be bed confined and have one or more of the following conditions: **Alternating Pressure Pad (E0181):** A physician may consider alternating pressure pads (APP) for Medicaid payment only when prescribed as medically necessary. Requests for the equipment must be received by EDS within ~~**seven working**~~ **thirty calendar days** after the date that the APP was dispensed. The following medical criteria must be met: **Gel or Gel-like Pressure Pad for Mattress (E0185):** Gel or gel-like pressure pads will be considered for Medicaid payment when prescribed as medically necessary by a physician. Request for coverage must be received by EDS within ~~seven working~~ **thirty calendar days** after the date that the equipment was dispensed. An eligible recipient must meet the following medical criteria: **Mattress Replacement (E0271):** To qualify for Medicaid reimbursement of a mattress replacement, a physician must prescribe the equipment as medically necessary. Request for coverage must be received by EDS within ~~**seven**~~		

Affected Chapter	*Description of Change*	*Remove old pages*	*Insert updated pages*
	~~**working**~~ **thirty calendar days** after the date that the equipment was dispensed. An eligible recipient must meet the following medical criteria: **Bed Side Rails (E0310):** A physician must prescribe bedside rails as medically necessary in order for a recipient to qualify for Medicaid reimbursement. EDS must receive the request for coverage within ~~**seven working**~~ **thirty calendar days** after the date that the equipment was dispensed. The recipient must be bed confined and have one or more of the following conditions: **Recipient Hydraulic Lift With Seat or Sling (E0630):** Recipient hydraulic lifts will be considered for Medicaid payment when prescribed as medically necessary by a physician. Request for coverage must be received by EDS within ~~**seven working**~~ **thirty calendar days** after the date that the equipment was dispensed. An eligible recipient must meet the following medical criteria: **Trapeze Bar, AKA Recipient Helper, Attached to Bed with Grab Bar (E0910):** To qualify for Medicaid reimbursement of a trapeze bar, the physician must prescribe the equipment as medically necessary for the recipient. Request for coverage must be received by EDS within ~~**seven working**~~ **thirty calendar days** after the date that the equipment was dispensed. The recipient must be essentially bed confined and must meet the following documented conditions: **Nebulizer (E0570): (Table)** Children 6 years of age or under - Short-term **Rentals** (6 months or less) are allowed for first time episodes associated with one of the above diagnoses. Supporting documentation must accompany the request. Recipients 18 years of age and above - **Rentals** are approved only on a short-term basis (6 months or less) for acute complications of pneumonia. Children and Adults - **Rentals** may be approved on a short-term basis (6 months or less) to administer medications as an alternative to intravenous administration of those drugs (for example, nebulized tobramycin, colistin, or gentamicin). Must be accompanied by supporting documentation. **Iron Chelation Therapy Equipment (Z5220, Z5221, Z5222, Z5223):** EDS must receive a prior authorization request after obtaining the above information within ~~**seven working**~~ **thirty calendar days** after the date that the equipment was dispensed. **Wheelchairs:** To qualify for Medicaid reimbursement of a wheelchair, the physician must prescribe the equipment as medically necessary for the recipient. Request for coverage must be received by EDS within ~~seven working~~ **thirty calendar days** after the date that the equipment was dispensed. **Low Pressure and Positioning Equalization Pad for Wheelchair (E0192) (K0108):** Requests for coverage must be received by EDS within ~~seven working~~ **thirty calendar days** after the date that the equipment was dispensed.		

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	Oxygen: Oxygen therapy is a covered service based on medical necessity and requires prior authorization. Requests for coverage must be received by EDS within ~~**seven working**~~ **thirty calendar days** after the oxygen equipment is dispensed. In order to receive a prior authorization number, forms ~~300~~ 360 and 342 must be completed and submitted to EDS. **Volume Ventilator – Stationary or Portable (E0450):** A ventilator is covered for EPSDT referred recipients. A physician must prescribe it as medically necessary. EDS must receive request for coverage within ~~**seven working**~~ **thirty calendar days** after the date the equipment was dispensed. The recipient must meet the following conditions: **Home Phototherapy (S9120)** Home phototherapy is a covered service with prior authorization in the DME Program for EPSDT referred recipients. To administer the treatment of phototherapy safely and properly in the home, an attending physician must prescribe it as medically necessary for hyperbilirubinemia. EDS must receive requests for coverage within ~~**seven working**~~ **thirty calendar days** after the first home phototherapy treatment. **Apnea Monitor (E0608):** The apnea monitor is a covered service with prior authorization in the DME program for EPSDT referred recipients. The apnea monitor can be provided only if it can be used properly and safely in the home and if it has been prescribed as medically necessary by a physician. Request for coverage must be received by EDS within ~~**seven working**~~ **thirty calendar days** after the date that the monitor was dispensed. **Section 14.3 Prior Authorization and Referral Requirements:** Certain DME requires prior authorization. Please refer to Section 14.5.3, Procedure Codes and Modifiers, for items that require prior authorization from Medicaid. Payment will not be made for these procedures unless the prior authorization request is received within ~~**seven working**~~ **thirty calendar days** after the service is provided. **Section 14.3.1 Authorization for Durable Medical Equipment:** Prior authorization requests for purchase, rental, or re-certification of DME must be received by Medicaid's fiscal agent within ~~**seven working**~~ **thirty calendar days** of the signature date the ~~physician prescribing the equipment~~ equipment was dispensed. Time limits for submitting requests for services and resubmitting additional information are as follows: • All prior authorization requests for the **purchase** of DME received beyond ~~**seven working**~~ **thirty calendar days** after equipment is provided will be denied. • All prior authorization requests for certification of **rental** services received beyond ~~**seven working**~~ **thirty calendar days** of beginning services will be authorized for reimbursement effective the date of receipt at EDS.		

Affected Chapter	*Description of Change*	*Remove old pages*	*Insert updated pages*
	• All prior authorization requests for re-certifications of DME rental services must be submitted to EDS within ~~**seven working**~~ **thirty calendar days** of the re-certification date. Completed re-certifications received beyond the established time limit will be authorized for reimbursement effective the date of receipt at EDS. **Hospital Beds Table:** ~~**K0456**~~ **K0549 -** Hospital bed heavy duty, extra wide ~~semi-electric (head and foot adjustments)~~ with any type side rails, with mattress. **EPSDT Referred Services Table:** ~~K0456~~ K0549 - Hospital bed heavy duty, extra wide with any type side rails, with mattress - Yes **External Insulin Pump & Supplies Table:** E0784 - External Ambulatory Infusion Pump will be limited to one every five years based on submitted documentation. This procedure code will be a capped rental item with rental payment of $360.00 per month for twelve months. At the end of the twelve month period, the item is considered to be a purchased item for the recipient paid in full by Medicaid. Any maintenance/repair cost would be subject to an EPSDT screening and referral and a prior authorization as addressed under current Medicaid policy. - Yes A4232 - Syringe with needle for External Insulin Pump, sterile 3cc (each) will be supplied in quantities prescribed as medically necessary by the physician. - No A4221 - Supplies for maintenance of drug infusion catheter per week will be limited to three supply kits per week; no more than twelve supply kits per month. These supply kits must be prescribed as medically necessary by the recipient's physician. If additional supply kits are needed, an EPSDT screening and referral and a prior authorization must be submitted to Medicaid for review. - No		
Chapter 15 Eye Care Services	**Section 15.2 Benefits and Limitations:** NOTE: The Agency establishes annual benefit limits on certain covered services. Benefit limits related to eye care services are established every two calendar years for recipients 21 years of age or older. Therefore, it is imperative Eye Care Providers furnishing services to recipients 21 years of age and older, verify benefit limits for the current year and the past year to determine if the eye care benefit limits have been exhausted. Providers who do not verify benefit limits for two calendar years (last year and current year) for recipient's 21 years of age and older risk a denial of reimbursement for those services. When the recipient has exhausted his or her benefit limit for a particular service, providers may bill the recipient. **Section 15.2.1 Examinations - Complete Eye Examinations:** The appropriate procedure codes to use when filing claims for a complete eye examination and work-up are codes 92004 and 92014. Please refer to Section 15.5.3 for additional information.	15-1 to 15-18	15-1 to 15-18

Affected Chapter	*Description of Change*	*Remove old pages*	*Insert updated pages*
	Section 15.2.2 Eyeglasses - Additional Eyeglasses and Eye Exams: If medically necessary, Medicaid may prior authorize additional eye exams and eyeglasses for treatment of eye injury, disease, or significant prescription change. The provider should forward ~~a letter to Medicaid justifying medical necessity prior to ordering the eyeglasses~~ an Alabama Prior Review and Authorization Request (Form 342) with a letter justifying necessity to EDS prior to ordering the eyeglasses. **Section 15.5 Completing the Claim Form:** **Routine Checkups and Medicare** Generally routine eye examinations are not covered by Medicare. However, Medicare covers treatment of eye diseases, for example, cataracts and glaucoma. When filing claims for routine eye exams you may file directly to Medicaid. If you are filing claims for medical conditions related to eyes, please file with Medicare before filing with Medicaid. **Other Situations** Providers may render special services for unusual situations upon prior authorization. Medicaid must receive full, written information justifying medical necessity prior to the service being rendered. Please refer to Chapter 4, Obtaining Prior Authorization for more information. **Section 15.5.3 Procedure Codes and Modifiers - Common Optometric Services** The Optometric Services listed below are those commonly used by Optometrists and Ophthalmologists. Procedure codes 92004 and 92014 should include a complete eye exam and work-up as outlined in Section 15.2.1. **Table is replaced** **Section 15.5.3 Procedure Codes and Modifiers - Miscellaneous Procedures:** 99311 - Subsequent Nursing Facility Care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three key components: • A problem focused interval history • A problem focused examination • Medical decision making that is straightforward or of low complexity 99312 - Subsequent Nursing Facility Care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three key components: • An expanded problem focused interval history • An expanded problem focused examination • Medical decision making of moderate complexity 99313 - Subsequent Nursing Facility Care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three key components: • A detailed interval history		

Affected Chapter	*Description of Change*	*Remove old pages*	*Insert updated pages*
	• A detailed examination • Medical decision making of moderate to high complexity **Section 15.5.3 Procedure Codes and Modifiers - Special Optometric Services:** **Table is replaced** **Section 15.5.3 Procedure Codes and Modifiers - Surgical Procedures:** **Table is replaced** **Contact Lenses Table:** Deleted one procedure code 92310 and replaced the second 92310 with 92310 - 52 - Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, both eyes, except for aphakia - Yes Replaced 92311 with 92311 - Corneal lens for aphakia, one eye - Yes Replaced 92312 with 92312 - Corneal lens for aphakia, both eyes - Yes Added to **Eyeglasses Codes - Lens Codes:** The frame specifications below are authorized at the specified contract price. Effective July 1, 2002, the locally assigned procedure codes for frames are converted to one of two codes (PC), V2020 and V2025. A special order frame is designated as V2025 and should be billed as $25.00. Procedure code V2020 is designated for all the other frame codes and **the amount billed should be according to the frame provided**. In other words, **providers should bill the price of the frame in this manual and not their usual and customary price for the frame.** **Bifocal Spherocylinder (plus or minus) Table:** V2210 - 4.2~~7~~5 - 7.00/over 6.00 cylinder - 8.80 **Frames: NOTE:** Use "Z" procedure codes for dates of service 6-30-02 and before when filing claims for eyeglass frames. Use "V" procedure code for dates of service 7-01-02 and after when filing claims for eyeglass frames. **Providers should bill the price of the frame in this manual and not their usual and customary price for the frame.** **Section 15.5.3 Procedure Codes and Modifiers - Unisex Frames:** V2020 - Z5152 - Boulevard 4508 Hart (may substitute Ellen Phil Optiks) - 10.95		
Chapter 16 Federally Qualified Health Centers (FQHC)	**No changes**	16-1 to 16-10	16-1 to 16-10
Chapter 17 Home Health	**No changes**	17-1 to 17-8	17-1 to 17-8

Affected Chapter	*Description of Change*	*Remove old pages*	*Insert updated pages*
Chapter 18 Hospice	**Section 18.2.2 Election Procedures:** An election period is any one of ~~four~~ three periods in a person's lifetime during which an individual may elect to receive medical coverage of hospice care. **Section 18.2.9 Reimbursement for Levels of Care - Reimbursement for Physician Services:** Physicians employed by or working under arrangements made with the hospice may bill for direct patient care services rendered ~~with the hospice provider indicated as the payee~~.	18-1 to 18-12	18-1 to 18-12
Chapter 19 Hospital	**Section 19.2 Benefits and Limitations Table:** 19.2.5 - Outpatient Services - Outpatient Hyperbaric Oxygen Therapy **Section 19.2.5 Outpatient Hospital Services - Outpatient Observation:** Providers should bill the appropriate CPT code based on the severity of the patient's condition. Providers may bill up to ~~twenty (~~20~~)~~ units of each procedure code. **Section 19.2.5 Outpatient Hospital Services - Outpatient Hyperbaric Oxygen Therapy (HBO):** Added entire section **Outpatient Observation** Providers should bill the appropriate CPT code based on the severity of the patient's condition. Providers may bill up to ~~twenty (~~20~~)~~ units of each procedure code. Outpatient observation charges cannot be billed in conjunction with outpatient surgery or critical care. (99285) **Section 19.4 Cost Sharing (Copayment)** The copayment amount for ~~an outpatient hospital~~ a non-certified emergency room visit (99281-99285) is $3.00 per visit or $3.00 per total bill for crossover outpatient hospital claims. **Section 19.5.1 Time Limit for Filing Claims** All in-state inpatient hospital claims follow Partnership Hospital Program (PHP) payment guidelines. PHP requires all claims to be filed by the last day of February of the following year ~~within 120 days of the end of the fiscal year~~ The fiscal year begins October 1 and ends September 30. ~~The filing deadline is the last day of February of the following year.~~ **Section 19.5.2 Revenue Codes, Procedure Codes, and Modifiers - Physical Therapy Table:** 95832 - Muscle, testing, manual, hand ~~Hand, with or without comparison to other side.~~ Deleted ~~97010 - Application of a modality to one or more areas, hot or cold packs - 1~~	19-1 to 19-34	19-1 to 19-34

Affected Chapter	*Description of Change*	*Remove old pages*	*Insert updated pages*
	Deleted ~~97140 - Manual therapy techniques (e.g., mobilization, manipulation, manual lymphatic drainage, manual traction) one or more regions, each 15 minutes - 1 - 4~~ 97535 - Self care/home management training, for example Activities of Daily Living (ADL), and compensatory training, meal preparation, safety procedures, and instructions in use of adaptive equipment), direct one on one contact by provider each 15 minutes - 4 - 12 **Occupational Therapy:** Deleted ~~The revenue code for occupational therapy is 430.~~ Added below NOTE: The revenue code for occupational therapy is 430. Hospitals may bill the following CPT codes for EPSDT referred OT services: Deleted the following CPT codes: ~~97110, 97112, 97114, 97118, 97120, 97124, 97126, 97126, 97128, 97145, 97240, 97241, 97500, 97501, 97521, 97531, 97540, 97541, 97700, 97720, 97721, 97762~~ Added the following CPT codes: 97022, 97032, 97033, 97034, 97035, 97036, 97110, 97112, 97124, 97504, 97535, 97542, 97703, 97750		
Chapter 20 Independent Laboratory	**No changes**	20-1 to 20-8	20-1 to 20-8
Chapter 21 Independent Certified Registered Nurse Practitioner (CRNP)	**No changes**	21-1 to 21-4	21-1 to 21-4
Chapter 22 Independent Radiology	**Section 22.5.3 Procedure Codes and Modifiers:** The Radiological professional component is billed by adding modifier 26 to the procedure code, and should be billed only for the following place of service locations: ♦ 21 (inpatient) ♦ 22 (outpatient) ♦ 23 (emergency room - hospital) ♦ 24 (ambulatory surgical center) ♦ 32 (nursing facility) ♦ 51 (inpatient psychiatric facility) ♦ 61 (comprehensive inpatient rehab facility) ♦ 62 (comprehensive outpatient rehab facility) ♦ 65 (end stage renal disease facility)	22-1 to 22-4	22-1 to 22-4
Chapter 23 Licensed Social Workers	**No changes**	23-1 to 23-4	23-1 to 23-4

Affected Chapter	*Description of Change*	*Remove old pages*	*Insert updated pages*
Chapter 24 Maternity Care Program	**Section 24 Maternity Care Program:** The purpose of this managed care effort is to ensure that every pregnant woman has access to medical care, with the goal of lowering Alabama's high infant mortality rate and improving overall maternal and infant health ~~overall~~. **Section 24.1 Enrollment Primary Care Contractor Table:** District 4 - ~~1-888-553-4485~~ to 1-877-533-4485 District 14 - USA Medical Center - (251) 415-8585 - (251) 415-8585 - n/a - 10/01/02 **Section 24.5.3 Procedure Codes and Modifiers** **59400 - ZE -** Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy or forceps) and postpartum care. ~~Patient must have entered care prior to 28 weeks and received a minimum of six (6) prenatal visits and other global components.~~ **59510 - ZE -** Routine obstetric care including antepartum care, cesarean delivery and postpartum care. ~~Patient must have entered care prior to 28 weeks and received and received a minimum of six (6) prenatal visits and other global components.~~ **Z5225 - Deleted** **Z5226 - Deleted** **Z5382 -** Maternity Care Drop-Out Fee. ~~This fee is payable only to the Primary Contractor and is for care coordination and administration costs. Medical services are to be billed by the actual provider of service following Medicaid program policies. Patient must have received a minimum of two (2) prenatal visits and the initial care coordinator encounter.~~ Patient must have been enrolled prior to delivery. **Section 24.5.3 Procedure Codes and Modifiers - Reimbursement for Services:** Global/delivery-only fees paid by Medicaid to the Primary Contractor represent payment in full. Beneficiaries may not be billed for any services covered under this ~~bid~~ program. ~~NOTE: The Administration Fee and Care Coordinator Fee are to be billed only when a recipient has been granted an exemption for third party liability (TPL) and can only be billed by the Primary Contractor.~~	24-1 to 24-14	24-1 to 24-12
Chapter 25 Nurse Midwife	**No changes**	25-1 to 25-8	25-1 to 25-8
Chapter 26 Nursing Facility	**No changes**	26-1 to 26-14	26-1 to 26-14
Chapter 27 Pharmacy	**No changes**	27-1 to 27-16	27-1 to 27-16
Chapter 28 Physician	**Section 28.2.2 Covered Services Table:** Psychiatric Services - For services rendered by psychologist, see ~~Appendix A, EPSDT~~ Chapter 34, for details. **Section 28.2.12 Lab Services - NOTE:** ~~84434~~ 84437 - Thyroxine; total requiring elution (e.g., neonatal)	28-1 to 28-22	28-1 to 28-24

Affected Chapter	*Description of Change*	*Remove old pages*	*Insert updated pages*
	Section 28.5.3 Procedure Codes and Modifiers - Physician-Employed Physician Assistants (PA) and Certified Registered Nurse Practitioners (CRNP): Payment will be made only for ~~injectable~~ physician drugs identified in Appendix H, Alabama Medicaid ~~Injectable~~ Physician Drug List, CPT codes identified in Appendix O, CRNP and PA Services, and laboratory services, which are CLIA certified. EPSDT screenings will be covered only if the provider is enrolled in that program. Refer to Appendix A, EPSDT, for EPSDT program requirements. **Section 28.5.3 Procedure Codes and Modifiers - Same Date Modifiers:** Modifier ~~GB~~ 59 should be used to indicate a separate distinct service. Do not confuse modifier ~~GB~~ 59 with modifiers for repeat procedures. Modifier ~~GB~~ 59 does not replace any existing modifiers. **Section 28.5.3 Procedure Codes and Modifiers - Same Date Modifiers Table:** ~~GB~~ 59 - Distinct procedural service modifier indicates that a crossover only service or procedure was distinct or separate from other services performed on the same day. This may represent a different session or patient encounter, different procedure or surgery, different site, separate lesion, or separate injury (or area of injury in extensive injuries). **Section 28.5.3 Procedure Codes and Modifiers - Same Date Modifiers Note:** NOTE: Modifier ~~GB~~ 59 is not to be used with Physician's Current Procedural Terminology (CPT) codes 99201-99499 or 77419-77430.		
Chapter 29 Podiatrist	**No changes**	29-1 to 29-4	29-1 to 29-4
Chapter 30 Preventive Health Education	**No changes**	30-1 to 30-6	30-1 to 30-6
Chapter 31 Private Duty Nursing	**Section 31.1 Enrollment - Enrollment Policy for Nursing Providers:** Private Duty Nursing providers enroll as EPSDT only. Only in-state private duty nursing providers and out-of-state providers within 30 miles of the state line qualify for participation in the Medicaid program. Private duty nursing providers must have a RN on staff. **Section 31.3 Prior Authorization and Referral Requirements -** • Home Health Certification and Plan of Care form (HCFA-485) for certification and recertification signed by the physician. • Medical update and Patient Information form (HCFA-486) signed by the physician • Private Duty Nursing Acceptance form • Any additional physician orders	31-1 to 31-8	31-1 to 31-8

Affected Chapter	*Description of Change*	*Remove old pages*	*Insert updated pages*
Chapter 32 Provider-Based Rural Health Clinics	**No changes**	32-1 to 32-6	32-1 to 32-6
Chapter 33 Psychiatric Facilities for Individuals under Age 21	**No changes**	33-1 to 33-6	33-1 to 33-6
Chapter 34 Psychologist	**No changes**	34-1 to 34-8	34-1 to 34-8
Chapter 35 Renal Dialysis Facility	**No changes**	35-1 to 35-6	35-1 to 35-6
Chapter 36 Rural Health Clinics/Independent	**No changes**	36-1 to 36-8	36-1 to 36-8
Chapter 37 Therapy (Occupational, Physical, and Speech)	**Section 37 Therapy (Occupational, Physical, and Speech):** Provider receives a referral as a result of an EPSDT screening exam and possesses ~~either an EPSDT Referral form (Form 167) or~~ a Patient 1st/EPSDT Referral form (Form 345<u>62</u>) as a result of an abnormality discovered during the EPSDT exam • Provider treats QMB ~~only~~ recipients **Section 37.3 Prior Authorization and Referral Requirements:** Deleted: Last sentence: ~~There are two Medicaid approved referral fpr service forms, Form 167 and Form 345.~~ **Section 37.5.3 Procedure Codes and Modifiers - Physical Therapy Table:** 95832 - ~~Hand, with or without comparison to other side.~~ <u>Muscle Testing manual</u> - 1 - 12	37-1 to 37-8	37-1 to 37-8
Chapter 38 Anesthesiology	**Section 38.2 Benefits and Limitations:** For billing purposes, anesthesia services rendered with medical <u>direction</u> ~~supervision~~ for one CRNA or AA is considered a service performed by the anesthesiologist. <u>The definition of medical direction is an anesthesiologist medically directing four concurrent cases (CRNA/AA) or less. In order to bill for medical direction, the anesthesiologist must be immediately physically available at all times.</u> Addressing an emergency of short duration, or rendering the requisite CRNA or AA <u>direction</u> ~~supervision~~ activities (listed below in a. through g.), within the immediate operating suite is acceptable as long as it does not substantially diminish the scope of the supervising anesthesiologist's control. If a situation occurs which necessitates the anesthesiologist's personal continuing involvement in a particular case, medical <u>direction</u> ~~supervision~~ ceases to be available in all other cases. In order for the anesthesiologist to be reimbursed for medical <u>direction</u> ~~supervision~~ activities of the CRNA or AA, the anesthesiologist must document the performance of the following activities: f. Remains ~~physically present and available~~ <u>immediately physically available</u> for immediate diagnosis and treatment of emergencies	38-1 to 38-10	38-1 to 38-10

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	A necessary task or medical procedure may be executed while concurrently medically directing CRNAs or AAs only if the task or procedure is one which may be: (1) immediately interruptible without ~~stopped instantly that would not~~ compromise~~ing~~ the wellbeing, quality of care, or health of the recipient and (2) is executed in an area close enough to the operating rooms where the CRNAs and AAs are being medically directed and that will permit the physician to remain in compliance with the requirements of ~~being physically present and available~~ immediately physically available. 2) labor epidural placement and management ~~for labor~~ The intent of this exception is to allow for provision of commonly requested procedures and to improve effectiveness. However, this exception does not include ~~diagnosis~~ consults to diagnose. Diagnosis ~~and/or treatment~~ of chronic pain ~~management~~ and treatment of complex problems is ~~are~~ not allowed while simultaneously medically directing CRNAs and AAs. **Global Anesthesia Definition:** Placement of lines such as arterial catheterizations and insertion and placement of ~~flow directed catheter~~ pulmonary artery catheters (e.g., Swan-Ganz) for monitoring will no longer be included in the global anesthesia reimbursement when billed with other procedures but will be allowed to be billed using the same guidelines outlined in this chapter under “Special Situations for Anesthesia”. ~~The time involved in arterial line insertion should be clearly documented in the narrative section of the anesthesia record.~~ The time of placement of invasive monitors and who placed them should be documented in the medical record.. Verification of anesthesia time units may be subject to post-payment audits. Billing for anesthesia time while placing invasive monitors is not allowed unless the patient required general anesthesia for placement. The time anesthesia starts is at the beginning of induction via the injection or inhalation of an anesthetic drug or gas and ends at the time the recipient is transferred to the ~~receiving room~~ recovery room or post anesthesia care unit (PACU). Induction is defined as the time interval between the initial injection or inhalation of an anesthetic drug or gas until the optimum level of anesthesia is reached. Up to 15 minutes are allowed for the preparation of anesthesia, and up to 15 minutes are allowed after the operation (for transfer of the recipient to the receiving room, recovery room, or PACU). ~~Overall the time of induction should be within a couple of minutes of the beginning of the operative session.~~ The recipient must be prepared by the anesthesiologist prior to induction and must be assessed by the anesthesiologist immediately after the surgical procedure. One time unit to prepare and one time unit after the operation (for transfer of the recipient to the receiving room, recovery room or PACU) is permissible. It is inappropriate to bill for anesthesia time while the patient is receiving blood products or antibiotics in the holding area or waiting in a holding		

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	area, or waiting in the operating room more than 15 minutes prior to induction. **Post-Operative Pain Management and Epidural Catheters**: Surgeons routinely ~~perform~~ provide necessary post-operative pain management services and are reimbursed for these services through the global surgery fee~~, including daily epidural pain management~~. The surgeon should manage post-operative pain except under extraordinary circumstances. Procedures involving major intra-abdominal, vascular and orthopedic, and intrathoracic procedures will be covered for post-operative pain management by an anesthesiologist when medically indicated. Postoperative pain management services is not covered by non-physicians. **Section 38.5.3 Procedure Codes and Modifiers - Qualifying Factors:** Beginning ~~August 16~~ June 14, 2002, qualifying factors will be reimbursable. Qualifying factors allow for anesthesia services provided under complicated situations depending on irregular factors (ex: abnormal risk factors, significant operative conditions). ~~Qualifying procedure code unit values will be multiplied by the price allowed for anesthesia services (see above paragraph)~~ The qualifying procedures would be reported in conjunction with the anesthesia procedure code on a separate line item using 1 unit of service. The qualifying procedure codes are indicated below. **Qualifying Factors Table:** Added Table **Section 38.5.3 Procedure Codes and Modifiers - Medical Supervision - CRNA or AA:** Medical direction should only be billed when the CRNA or AA supervision is rendered by an anesthesiologist. If a procedure is medically ~~directed~~ supervised by the surgeon, the claim should be billed as if the service were not medically directed. **Medical Supervision - Anesthesiologists:** Medically directed services are defined as anesthesia services that are medically directed by an anesthesiologist for 1, 2, 3, or 4 CRNAs or AAs. **Other Anesthesia Modifiers Note:** All procedures for anesthesiology services must include appropriate modifiers. CRNAs and AAs are limited to QX and QZ. Anesthesiologists are limited to QY, QK, AA, AB, and AC. Medical directing five or more concurrent cases is not allowed.		

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Chapter 39 Patient 1st Billing Manual	**Section 39.14 Patient 1st Billing Instructions - EPSDT and Patient 1st Referred Services:** To bill for a service that requires a Patient 1st referral, the billing provider must have a valid signed referral form in the recipient's medical record. This form should contain the PMP's number to use for billing. If a service does not require a Patient 1st referral it is not necessary to get a referral from the PMP and it is not necessary to retain a referral form in the recipient's medical record. A list of the Patient 1st services "requiring" and "not requiring" a written signed referral are listed in the Alabama Medicaid Provider Manual in Chapter 39 on pages 15 –18.	39-1 to 39-24	39-1 to 39-24
Chapter 100 Children's Specialty Clinics	**Section 100 Children's Specialty Clinics:** Clinics added: Neuromotor, Seating, Teen Transition **Section 100.5.3 Procedure Codes and Modifiers - Clinic Services Table:** Z5146 - added Neuromotor Clinic Z5148 - added Seating Clinic and Teen Transition Clinic Added CRS CLINIC TEAMS table	100-1 to 100-10	100-1 to 100-14
Chapter 101 County Health Departments	**No changes**	101-1 to 101-6	101-1 to 101-6
Chapter 102 Intermediate Care Facility for the Mentally Retarded (ICF-MR)	**No changes**	102-1 to 102-6	102-1 to 102-6
Chapter 103 Local Education Agencies (LEAs)	**No changes**	103-1 to 103-20	103-1 to 103-20
Chapter 104 Psychiatric Hospital (Recipients 65 & Over)	**No changes**	104-1 to 104-8	104-1 to 104-8
Chapter 105 Rehabilitative Services - DHR, DYS, DPH, DMH	**Section 105 Rehabilitative Services - DHR, DYS, DPH, DMH:** Rehabilitative services are specialized medical services delivered by uniquely qualified practitioners designed to treat or rehabilitate persons with mental illness, ~~or~~ substance abuse, or co-occurring mental illness and substance abuse diagnoses. These services are provided to recipients on the basis of medical necessity. **Section 105.2 Benefits and Limitations:** Treatment eligibility is limited to individuals with a diagnosis within the range of 290-316, assigned by a licensed physician or psychologist, of mental illness or substance abuse as listed in the most current International Classification of Diseases - Clinical Modification (ICD-CM). **Section 105.2.1 Covered Services - Intake Evaluation (Z5227):** Eligible Staff - Mental Illness Services/~~Adult Protective Services~~	105-1 to 105-48	105-1 to 105-48

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	Intake Evaluation (Z5227) - Eligible Staff - Child and Adolescent Services/Adult Protective Services: An individual employed by a public provider department who meets the state merit system qualifications for Social Service Caseworker ~~Social Worker I~~, Public Health Social Worker I, or Youth Services Counselor II or above, or an employee of an agency or entity under contract to serve the target population of one of the same public provider agencies who meets an approved equivalency for Social Service Caseworker ~~Worker I~~, Public Health Social Worker I, Youth Services Counselor II, or above. **Section 105.2.1 Covered Services - Crisis Intervention and Resolution (Z5230) - Eligible Staff - Child and Adolescent Services/Adult Protective Services:** Services may be provided by an individual employed by a public provider department who meets the state merit system qualifications for Social Service Caseworker ~~Social Worker I~~, Public Health Social Worker I, or Youth Services Counselor II or above, or an employee of an agency or entity under contract to serve the target population of one of the same public provider agencies who meets an approved equivalency for Social Service Caseworker ~~Worker I~~, Public Health Social Worker I, Youth Services Counselor II, or above. **Section 105.2.1 Covered Services - Treatment Plan Review (Z5242):** • A ~~licensed~~ psychologist licensed under Alabama law • A marriage and family therapist licensed under family law **Section 105.2.1 Covered Services - Mental Health Consultation (Z5243) - Eligible Staff - Child and Adolescent Services/Adult Protective Services:** Mental health consultations for child and adolescent services/adult protective services clients may be delivered by an individual employed by a public provider department who meets the state merit system qualifications for Social Service Caseworker ~~Social Worker I~~, Public Health Social Worker I, or Youth Services Counselor II or above, or an employee of an agency or entity under contract to serve the target population of one of the same public provider agencies who meets an approved equivalency for Social Service Caseworker ~~Worker I~~, Public Health Social Worker I, Youth Services Counselor II, or above. **Section 105.2.1 Covered Services - Basic Living Skills (Z5236 – Individual; Z5237 – Group) - Eligible Staff – Mental Illness, Substance Abuse, and Child and Adolescent Services/Adult Protective Services:** Is employed by a public provider department and meets the state merit system qualifications for Social Service Caseworker ~~Social Worker I~~, Public Health Social Worker I, or Youth Services		

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	Counselor II or above, or is an employee of an agency or entity under contract to serve the target population of one of the same public provider agencies and meets an approved equivalency for Social Service Caseworker ~~Worker I~~, Public Health Social Worker I, Youth Services Counselor II, or above **Section 105.2.1 Covered Services - Family Support (Z5238 – Individual; Z5239 – Group) - Eligible Staff – Mental Illness, Substance Abuse, and Child and Adolescent Services/Adult Protective Services:** Is employed by a public provider department and meets the state merit system qualifications for Social Service Caseworker ~~Social Worker I~~, Public Health Social Worker I, or Youth Services Counselor II or above, or is an employee of an agency or entity under contract to serve the target population of one of the same public provider agencies and meets an approved equivalency for Social Service Caseworker ~~Worker I~~, Public Health Social Worker I, Youth Services Counselor II, or above **Section 105.2.3 Requirements for Client Intake, Treatment Planning, and Service Documentation:** Added paragraph: The preferred course of treatment for persons with co-occurring disorders (MI/SA) is integrated services where both mental illness and substance abuse clinical issues are addressed in the same treatment setting, whether that setting primarily provides mental illness or substance abuse treatment. In cases where integrated services are not possible, a dually diagnosed client may receive mental illness and substance abuse services simultaneously from one or more certified providers. In cases where mental illness and substance abuse services are provided independently, the daily caps specific to each service are cumulative for the day and are not interactive. In all cases, the diagnosis and treatment plan should reflect both disorders and the interventions needed for both. **Section 105.5.2 Diagnosis Codes:** NOTE: ICD-9 diagnosis codes, within the range of 290-316, must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field. The code V629 is covered only for children and adolescents or adults receiving DHR protective services.		
Chapter 106 Targeted Case Management	**No changes**	106-1 to 106-16	106-1 to 106-16
Chapter 107 Waiver Services	**Section 107 Waivered Services:** Changed Waivered to Waiver **Section 107 Waiver Services:** Medicaid covers home and community-based services (HCBS) through the Elderly and Disabled (E&D) Waiver ~~(E&D)~~ and the Homebound Waiver to categorically needy individuals who would	107-1 to 107-22	107-1 to 107-26

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	otherwise require institutionalization in a nursing facility. Medicaid covers HCBS through the Mentally Retarded/Developmentally Disabled (MR/DD) Waiver ~~(MR/DD)~~ and the Living at Home (LHW) Waiver to Medicaid-eligible individuals who would otherwise require the level of care available in an intermediate care facility for the mentally retarded ~~developmentally disabled~~ (ICF-MR). The purpose of providing HCBS to individuals at risk of institutional care is to protect the health, safety, and dignity of those individuals while reducing Medicaid expenditures for institutional care. Services that are reimbursable through Medicaid's EPSDT Program shall not be reimbursed as waiver Service. HCBS are provided through a Medicaid waiver for an initial period of three years and for five-year periods thereafter upon renewal of waiver by the ~~Health Care Financing Administration~~ Centers for Medicare Medicaid Services (CMS). The E&D Waiver is a cooperative effort among the Alabama Medicaid Agency, Alabama Department of Public Health, and the Alabama ~~Commission on Aging~~ Department of Senior Services (ADSS). The policy provisions for E&D Waiver providers can be found in the *Alabama Medicaid Agency Administrative Code*, Chapter 36. The MR/DD and LHW Waiver is a cooperative effort between the Alabama Medicaid Agency and the Alabama Department of Mental Health and Mental Retardation. The policy provisions for MR/DD and LHW Waiver providers can be found in the *Alabama Medicaid Agency Administrative Code*, Chapters 35 and 52 respectively. The Living at Home Waiver (LHW) is a cooperative effort between the Alabama Medicaid Agency and the Alabama Department of Mental Health and Mental Retardation. The policy provisions for Living at Home Waiver providers can be found in the *Alabama Medicaid Agency Administrative Code*, Chapter 52. **Section 107.1 Enrollment - Provider Number, Type, and Specialty:** Providers of waiver~~ed~~ service are assigned a provider type of 78 (Waiver~~ed~~ Service). Valid specialties for these providers include the following: • Elderly and Disabled Waiver (ED) • Homebound Waiver (EC) • MR/DD Waiver (EE) • Living at Home Waiver (EF) **Section 107.2 Benefits and Limitations:** Added to table: Home and community-based services for Living at Home Waiver - In-home Residential Habilitation Day Habilitation - Levels 1-3 Supported Employment Prevocational Services		

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	In-Home Respite Out-of-Home Respite Personal Care Personal Care Personal Care Transportation Physical Therapy Occupational Therapy Speech Therapy Behavior Therapy Skilled Nursing Environmental Accessibility Adaptations Specialized Medical Equipment Community Specilaist Crisis Intervention **Section 107.2.1 Financial Eligibility:** Financial eligibility for Living at Home Waiver is limited to the following individuals: • AFDC • SSI recipients **Section 107.2.3 Limitations:** Medicaid or its ~~administering~~ operating agencies may deny home and community-based services if it determines that an individual's health and safety is at risk in the community~~; if the cost of serving an individual on the waiver exceeds the cost of caring for that individual in a nursing facility~~; if the individual does not cooperate with a provider in the provision of services; and if an individual meets the goals and objectives of being on the waiver program. NOTE: Homebound waiver recipients must be aged~~~~ 18 years or older. LH waiver recipients must be age 3 years or older. **Section 107.2.4 Explanation of Covered Services - Day Habilitation (Z5201 – MR/DD; Z520F (Level 1) LHW; Z5260 (Level 2) LHW; Z5261 (Level 3) LHW):** *****The level utilized for Day habilitation services in the LHW is determined by the individual's ICAP score. **Added to headings:** **Respite Care (Z5204 – In-Home; Z5205 – Out-of-Home – MR/DD & LHW)** **Residential Habilitation - Other Living Arrangement (OLA) (Z5343 – MR/DD & LHW)** **Supported Employment (Z5345 – MR/DD & LHW)** **Prevocational Services (Z5346 – MR/DD & LHW)** **Physical Therapy (Z5347 – MR/DD & LHW)** **Occupational Therapy Services (Z5348 – MR/DD & LHW)**		

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	Speech and Language Therapy (Z5349 – MR/DD <u>& LHW</u>) **Personal Care (Z5352 – MR/DD <u>& LHW</u>)** <u>Although personal care is not available to residents of a group home or SCLH in the MR/DD waiver, under the LHW, personal care may be approved by the Division of Mental Retardation for specific purposes that are not duplicative.</u> **<u>Personal Care Transportation (Z5259 – LHW)</u>** Added entire section **Behavior Management <u>Therapy</u> (Z5354 – MR/DD <u>& LHW</u>)** **Environmental Accessibility Adaptations (Z5355 – MR/DD <u>& LHW</u>, Z5305 – Homebound)** <u>Total costs of environmental accessibility adaptations under the LHW shall not exceed $5,000 per year, per individual.</u> **Medical Supplies (Z5356 – MR/DD <u>& LHW</u>)** <u>Medicaid reimbursement for this service under the MR/DD waiver is limited to $1,800 per client, per waiver year. Medicaid reimbursement for this service under the LHW is limited to $5,000 per client, per waiver year.</u> ~~Medicaid reimbursement is limited to $1800 per waiver year for this services.~~ **Skilled Nursing (Z5358 – MR/DD <u>& LHW</u>)** **Section 107.2.5 Characteristics of Persons Requiring ICF-MR Level of Care Through the MR/DD Waiver <u>and Living at Home Waiver</u>** **Determining Eligibility for MR/DD <u>and LH Waiver</u>** Determination regarding eligibility for care under the MR/DD <u>& LH</u> Waiver is made by a Qualified Mental Retardation Professional (QMRP). **Individual Assessments:** Medicaid requires an individual plan of care for each MR/DD <u>& LH</u> waiver service recipient. Recipients are re-evaluated on an annual basis. Written documentation of all assessments is maintained in the recipient's case file and is subject to review by Medicaid and ~~the Health Care Financing Administration~~ <u>CMS</u>. Re-evaluations are done on an annual basis or when needed. Written documentation of all assessments is maintained in the recipient's case file and is subject to review by Medicaid and ~~the Health Care Financing Administration~~ <u>CMS</u>. **Section 107.2.8 Records Used for Medicaid Audits:** The state agencies as specified in the approved waiver document as ~~administered~~ <u>operating</u> agencies of home and community-based services, will have their records audited at least annually at the discretion of the Alabama Medicaid Agency. The Quarterly Cost Report includes all actual costs incurred by the ~~administering~~ <u>operating</u> agency for the previous quarter and include costs incurred for the current year-to-date. Cost reports for the Homebound Waiver must be received on or before June 1. <u>Providers of the LHW are not required to submit uniform cost reports. The</u>		

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	method of payment is on a fee-for-service basis. **Section 107.2.9 HCBS Payment Procedures:** Medicaid pays providers the actual cost to provide the service. Each covered service is identified on a claim by a procedure code. Respite care will have one code for skilled and another for unskilled~~, hence, six procedure codes~~. The basis for the ~~rates~~ fee is usually based on audited past performance with consideration ~~being~~ given to the health care index and renegotiated contracts. The interim ~~rates~~ fees may also be changed if a provider can show that an unavoidable event(s) has caused a substantial increase or decrease in the provider's cost. ~~Actual cost and units of services provided during a waiver year must be accounted on HCFA Form 372. The following accounting definitions are used to capture reporting data and audited figures used in establishing new interim fees:~~ ~~A waiver year consists of the 12 months following the start of any waiver year.~~ ~~An expenditure occurs when cash or its equivalent is paid in a quarter by a state agency for waiver benefits. For a public (governmental) provider, the expenditure is made whenever it is paid or recorded, whichever is earlier. Non-cash payments, such as depreciation, occur when transactions are recorded by the state agency.~~ ~~The services provided by administering agencies are reported and paid by dates of service. All services provided during the 12 months of the waiver year are attributed to that year.~~ ~~The provider's costs are divided between benefit and administrative cost. The benefit portion is included in the rate for service. The administrative portion is divided into 12 equal amounts and is invoiced by the provider directly to Medicaid. Since administration is a relatively fixed expense, it is not a rate per claim, but a set monthly payment. As each waiver year is audited, this cost, like the benefit cost, will be determined and lump sum settlement will be made to adjust that year's payments to actual cost.~~ ~~Medicaid pays providers the actual cost to provide the service. Each covered service is identified on a claim by a procedure code.~~ ~~All claims for services must be submitted within six months from the date of service. At the close of the waiver year, the providers will be audited and a final rate will be calculated based on actual allowable cost for the year divided by the number of services provided during the year. Any difference between the actual allowable cost and the revenues received based on the interim rate will be adjusted.~~ For each recipient, the claim will allow span billing for a period up to one month. There may be multiple claims in a month; however, no single claim can cover services performed in different months. For example, 10/15/02 to 11/15/02 would not be allowed. If the submitted claim covers dates of service part or all of which were covered in a		

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	previously paid claim, the claim will be rejected. Payment will be based on the number of units of service reported on the claim for each procedure code. The Operating Agencies (OA), as specified in the approved waiver document are governmental agencies and will receive actual cost for services rendered. The actual fee for service may differ among OAs. Accounting for actual cost and units of services provided during a waiver year must be captured on HCFA Form 372. The following accounting definitions will be used to capture reporting data, and the audited figures used in establishing new interim fees: A waiver year consists of twelve consecutive months starting with the approval date specified in the approved waiver document. An expenditure occurs when cash or its equivalent is paid in a quarter by a state agency for waiver benefits. For a public/governmental provider, the expenditure is made whenever it is paid or recorded, whichever is earlier. Non-case payments, such as depreciation, occur when transactions are recorded by the state agency. The services provided by an operating agency is reported and paid by dates of service. Thus, all services provided during the twelve months of the waiver year will be attributed to that year. The provider's costs shall be divided between benefit and administrative cost. The benefit portion is included in the fee for service. The administrative portion will be divided in twelve equal amounts and will be invoiced by the provider directly to the Alabama Medicaid Agency. Since Administration is relatively fixed, it will not be a rate per claim, but a set monthly payment. As each waiver is audited, this cost, like the benefit cost, will be determined and lump sum settlement will be made to adjust that year's payments to actual cost. The Alabama Medicaid Agency's Provider Audit/Reimbursement Division maintains the year-end cost reports submitted by the Alabama Department of Public Health (ADPH) and the Alabama Department of Senior Services (ADSS). Providers must retain records that fully disclose the extent and cost of services provided to the eligible recipients for a five (5) year period. These records must be accessible to the Alabama Medicaid Agency and appropriate state and federal officials. There must be a clear differentiation between waiver services and non-waiver services. There must be a clear audit trail from the point a service is provided through billing and reimbursement. The OA, Alabama Medicaid Agency and Centers for Medicare and Medicaid Services (CMS) must be able to review the Plan of Care to verify the exact service and number of units provided, the date the service was rendered, and the direct service provider for each recipient. There must be a detailed explanation of how waiver services are segregated from ineligible waiver costs.		

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	Section 107.2.10 Records for Quality Assurance Audits: The ~~administering~~ operating agencies for the E&D, Homebound, ~~and~~ MR/DD and LH waivers are required to maintain all records pertaining to the waiver recipients. They should also maintain the following information for audit purposes: **Section 107.3 Prior Authorization and Referral Requirements:** ~~The case manager then submits the assessment to Medicaid Long Term Care (LTC) Admission/Records Unit for approval.~~ ~~Medicaid reviews the application and determines if the individual meets the criteria for nursing facility care. If the application is approved, the applicant and the case manager will be notified in writing. If the application is denied, the applicant and the case manager will be notified and the reconsideration process will be explained in writing.~~ ~~An approved application is given a payment authorization date for the approved level of care. No charges for services rendered under the waiver program prior to this approved payment date will be paid.~~ ~~The case manager must submit a current assessment document, a new care plan, and a medical need admission form to Medicaid at each re-determination of eligibility, which occurs at least every 12 months.~~ The Alabama Medicaid Agency requires providers to submit an application in order to document dates of service provision to long term care recipients maintained by the long term care file. Application approvals will be done automatically through systematic programming. The LTC Admissions/Records Unit will perform random audits on a percentage of records to ensure that documentation exists to support the medical level of care criteria, physician certification, as well as other state and federal requirements. Case managers and/or designated staff of the HCBS waiver Operating Agency(ies) will assess the client to determine the risk for institutionalization and determine if the medical level of care is met according to Medicaid criteria. Assessment data will be entered and submitted electronically through the use of the EDS Bulletin Board System. If problems are encountered such as mismatched Social Security Numbers and/or Medicaid numbers, date conflicts, invalid provider numbers, or financial ineligibility, the auto-application will be denied and returned. Information will be provided to the user of the appropriate action(s) to take to correct the problem and will be allowed to resubmit the application. The application, upon completion of processing, will systematically assign approval dates in one-year increments. For initial assessments, once the application is submitted with an indication of an initial assessment, the system will apply the begin date as the date of submission plus one year, which is extended to the last day of the month. For re-determinations, the application is submitted with an indication of a re-determination and the system will		

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	pick up the end date already on the file and extend for one year. No charges for services rendered under the waiver program prior to the approval payment dates will be paid. **Fair Hearings:** An individual whose application to the waiver program is denied may request a hearing through the appropriate ~~administering~~ operating agency (the Alabama Department of Public Health, the Alabama ~~Commission on Aging~~ Department of Senior Services, the Alabama Department of Rehabilitation Services, or the Alabama Department of Mental Health/Mental Retardation). **Section 107.4 Cost Sharing (Copayment):** Copayment does not apply to services provided by Waiver~~ed~~ service~~s~~ providers. **Section 107.5 Completing the Claim Form:** Waiver~~ed~~ service~~s~~ providers who bill Medicaid claims electronically receive the following benefits: **Section 107.5.1 Time Limit for Filing Claims:** The ~~administering~~ operating agencies for the E&D waiver have 120 days at the end of the waiver year to process claims. The ~~administering~~ operating agencies for the MR/DD, Homebound, and LH waivers have 180 days at the end of the waiver year to process claims. ~~At the close of the waiver year, Medicaid audits the administering agency and calculates a final rate based on actual allowable cost for the year divided by the number of services provided during the year. Medicaid adjusts any difference between the actual allowable cost and the revenues received based on the interim rate. Refer to Section 5.1.5, Filing Limits and Approved Exceptions, for more information regarding timely filing limits and exceptions.~~ Living at Home waiver claims are to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions. **Section 107.5.3 Procedure Codes Table:** **Z5404** - Evaluation for Assistive Technology - Reimbursement will be standard cost per evaluation. – Yes **Z5405** - Assistive Technology Repairs - Reimbursement for repairs limited to $2000 annually per recipient. - No **Added Table:** The following procedure codes apply when filing claims for Living at Home Waiver services: Z5343-In-Home Residential Habilitation (per hour)-Yes Z5201-Day Habilitation (Level 1) – (per day)-Yes Z5260-Day Habilitation (Level 2) – (per day)-Yes Z5261-Day Habilitation (Level 3) – (per day)-Yes Z5345-Supported Employment (per day)-Yes Z5346-Prevocational Services (per day)-Yes Z5204-Respite In-Home (per hour)-Yes Z5205-Respite Out-of-Home (per hour)-Yes Z5352-Personal Care (per hour)-Yes Z5259-Personal Care Transportation (per mile)-Yes		

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	Z5347-Physical Therapy (per hour)-Yes Z5348-Occupational Therapy (per hour)-Yes Z5349-Speech Therapy (per hour)-Yes Z5354-Behavior Therapy (per hour)-Yes Z5358-Skilled Nursing (per hour)-Yes Z5355-Environmental Accessibility Adaptations (per job)-Yes Z5356-Specialized Medical Equipment/Supplies (per item)-Yes Z5258-Community Specialist (per hour)-Yes Z5257-Crisis Intervention (per hour)-Yes NOTE: All services for the LHW require prior authorization (PA). The PA number issued authorizes the service(s) to be provided, the length of time that the service(s) should be provided to the client, and the maximum units of each service that should be rendered to the individual as indicated in the authorized plan of care. **Section 107.5.4 Place of Service Codes:** The following place of service codes apply when filing claims for Waivered services: 12-Home (Residential) – MR/DD, Homebound Waiver, LHW 99-Other Unlisted Facility – MR/DD, Elderly & Disabled Waiver, LHW		

Affected Chapter	*Description of Change*	*Remove old pages*	*Insert updated pages*
Appendix A Well Child Check-Up	**Section A.3.7 Billing for Patient 1st Referred Services:** Added entire section **Section A.4.2 Referrals Resulting from a Diagnosis:** Added third paragraph EPSDT referrals are valid for only one year from the date of the EPSDT screening. Therefore the maximum time an EPSDT referral is valid is 12 months from the date of the well child check-up (EPSDT screening). The EPSDT screening date must be current to be valid. The EPSDT screening date may not be backdated or future dated. The date of the EPSDT screening should be documented under "Type of Referral" on form 362, the Alabama Medicaid Agency Referral Form. The EPSDT screening date documented on the Referral Form is the date used to determine the length of time an EPSDT referral is valid (regardless of a Patient 1st referral). The "Length of Referral" is used to determine the amount of time the referral is valid from the referral date and is inclusive of all types of referrals (e.g., Patient 1st referral, EPSDT referral, Targeted Case Management, etc). Please refer to Appendix E, Medicaid Forms, for additional information.	A-1 to A-38	A-1 to A-40
Appendix B Electronic Media Claims (EMC) Guidelines	**No changes**	B-1 to B-6	B-1 to B-6
Appendix C Family Planning	**No changes**	C-1 to C-30	C-1 to C-30
Appendix D Managed Care	**No changes**	D-1 to D-10	D-1 to D-10
Appendix E Medicaid Forms	**Section E Medicaid Forms Table:** Updated table to reflect correct forms and contact information. **Added Instructions for completion of form #362 E.25 Alabama Medicaid Agency Referral Form.**	E-1 to E-34	E-1 to E-36
Chapter F Medicaid Internal Control Numbers (ICN)	**No changes**	F-1 to F-4	F-1 to F-4
Chapter G Non-Emergency Transportation (NET) Program	**No changes**	G-1 to G-6	G-1 to G-6
Appendix H Alabama Medicaid Injectable Drug List	**Section H Alabama Medicaid ~~Injectable~~ Physician Drug List:** Replaced the reference to injectable to read physician throughout section. **Section H.1.2 Office Visits and Injections – Units of Service:** Physician drug prices are calculated based on a "per dose" basis, unless otherwise indicated by the narrative of the code. Some dosages are inherent in the narrative description of the codes and will assist in determining the number of units to file. When administering a lesser or greater dosage than what the per unit rate assumes to be one dose, providers should round the billing unit up to the closest amount charted. For example, J0290, Ampicillin, up to 500 mg:	H-1 to H-22	H-1 to H-22

Affected Chapter	*Description of Change*	*Remove old pages*	*Insert updated pages*
	Section H.2 Physician Drug List by Name: J9310 - Rituximab (Rituxa), 100 mg A9502-Supply of radiopharmaceutical diagnostic imaging agent, technetium Tc 99M Sestami6i, per unit dose A9503-Supply of radiopharmaceutical diagnostic imaging agent, technetium Tc 99M, medronate, up to 30 MCI A9504-Supply of radiopharmaceutical diagnostic imaging agent, Technetium Tc 99M Apcitide A9600-Supply of therapeutic radiopharmaceutical, strontium-89 Chloride, per MCI A9700-Supply of injectable contrast material for use in echocardiography, per study **Section H.2 Chemotherapy Drugs by Name:** S0112-Darbepoetin Alfa, SQ, 1 mcg **H.2 Miscellaneous Drugs and Solutions by Name:** A9502 - Supply of radiopharmaceutical diagnostic imaging agent, ~~technetium~~ Tc 99M sestamibi per unit dose **H.3 Physician Drug List by Procedure Code:** J9310 - Rituximab (Rituxa), 100 mg A9502-Supply of radiopharmaceutical diagnostic imaging agent, technetium Tc 99M Sestami6i, per unit dose A9503-Supply of radiopharmaceutical diagnostic imaging agent, technetium Tc 99M, medronate, up to 30 MCI A9504-Supply of radiopharmaceutical diagnostic imaging agent, Technetium Tc 99M Apcitide A9600-Supply of therapeutic radiopharmaceutical, strontium-89 Chloride, per MCI A9700-Supply of injectable contrast material for use in echocardiography, per study **Section H.3 Chemotherapy Drugs by Code:** S0112-Darbepoetin Alfa, SQ, 1 mcg **H.3 Miscellaneous Drugs and Solutions by Code:** A9502 - Supply of radiopharmaceutical diagnostic imaging agent, ~~technetium~~ Tc 99M sestamibi per unit dose		
Chapter I Outpatient Surgical List	**No changes**	I-1 to I-26	I-1 to I-26
Appendix J Provider Explanation of Benefits (EOB) Codes	**Section J.1 EOB Codes:** 174-Diagnosis requires accident indicator occurrence code. 175-Operation or delivery requires surgical procedure code.	J-1 to J-16	J-1 to J-22
Chapter K Top 200 Third Party Carrier Codes	**No changes**	K-1 to K-8	K-1 to K-8

Affected Chapter	*Description of Change*	*Remove old pages*	*Insert updated pages*
Chapter L AVRS Quick Reference Guide	**No changes**	L-1 to L-22	L-1 to L-22
Chapter M Reserved for future use	**No changes**	M-1 to M-2	M-1 to M-2
Chapter N Alabama Medicaid Contact Information	**No changes**	N-1 to N-4	N-1 to N-4
Appendix O CRNP and PA Services	**Section O CRNP and PA Services:** CRNP and PA services are **limited** to the injectable drug codes found in Appendix H, Alabama Medicaid ~~Injectable~~ Physician Drug Listing, all laboratory services, which are CLIA certified, and the following CPT codes.	O-1 to O-4	O-1 to O-4